

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN1884AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/06/2009
NAME OF PROVIDER OR SUPPLIER THE COURT AT RENO		STREET ADDRESS, CITY, STATE, ZIP CODE 3105 PLUMAS ST RENO, NV 89509		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a requested grading re-survey conducted in your facility 3/5-6/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 56 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The following deficiencies were identified:	Y 000		
Y 257 SS=B	449.217(7) Inspections-Approved by BHPS NAC 449.217 7. The equipment used for cooking and storing food and for washing dishes in a residential facility with more than 10 residents must be inspected and approved by the Bureau of Health Protection Services of the Division and the state and local fire safety authorities. This Regulation is not met as evidenced by: Based on observation and interview on 3/6/09, the facility did not ensure all refrigerators and microwaves were commercial grade; that in Country House there was no mold on the surfaces above the sink and the area around the toaster was not damaged.	Y 257		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 257	Continued From page 1 Severity: 1 Scope: 2	Y 257			

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